

1. CIR./DIST./ DIV. CODE		2. PERSON REPRESENTED		VOUCHER NUMBER	
3. MAG. DKT./DEF. NUMBER		4. DIST. DKT./DEF. NUMBER		5. APPEALS DKT./DEF. NUMBER	
6. OTHER DKT. NUMBER					
7. IN CASE/MATTER OF (Case Name)		8. PAYMENT CATEGORY		9. TYPE PERSON REPRESENTED	
		<input type="checkbox"/> Felony <input type="checkbox"/> Petty Offense		<input type="checkbox"/> Adult Defendant <input type="checkbox"/> Appellant	
		<input type="checkbox"/> Misdemeanor <input type="checkbox"/> Other		<input type="checkbox"/> Juvenile Defendant <input type="checkbox"/> Appellee	
		<input type="checkbox"/> Appeal		<input type="checkbox"/> Other:	
10. REPRESENTATION TYPE (See Instructions)					
11. OFFENSE(S) CHARGED (Cite US. Code, Title & Section) If more than one offense, list (up to five) major offenses charged, according to severity of offense.					

REQUEST AND AUTHORIZATION FOR EXPERT SERVICES

12. ATTORNEY'S STATEMENT	
<input type="checkbox"/> As the attorney for the person represented who is named above, I hereby affirm that the services requested are necessary for adequate representation. I hereby request:	
<input type="checkbox"/> Authorization to obtain the service. Estimated Compensation and Expenses: \$ _____ OR	
<input type="checkbox"/> Approval of services already obtained to be paid for by the United States pursuant to the Criminal Justice Act. (Note: Prior authorization should be obtained for services in excess of \$300, excluding expenses)	
Signature of Attorney _____ Date _____	
<input type="checkbox"/> Panel Attorney <input type="checkbox"/> Retained Attorney <input type="checkbox"/> Pro-Se <input type="checkbox"/> Legal Organization	
ATTORNEY'S NAME (First Name, M.I., Last Name, including any suffix), AND MAILING ADDRESS _____	
Telephone Number _____	

13. DESCRIPTION OF AND JUSTIFICATION FOR SERVICES (See Instructions)		14. TYPE OF SERVICE PROVIDER	
		01 <input type="checkbox"/> Investigator	
		02 <input type="checkbox"/> Interpreter/Translator	
		03 <input type="checkbox"/> Psychologist	
		04 <input type="checkbox"/> Psychiatrist	
		05 <input type="checkbox"/> Polygraph	
		06 <input type="checkbox"/> Documents Examiner	
		07 <input type="checkbox"/> Fingerprint Analyst	
		08 <input type="checkbox"/> Accountant	
		09 <input type="checkbox"/> CALR (Westlaw/Lexis, etc.)	
		10 <input type="checkbox"/> Chemist/Toxicologist	
		11 <input type="checkbox"/> Ballistics	
		13 <input type="checkbox"/> Weapons/Firearms/Explosive Expert	
		14 <input type="checkbox"/> Pathologist/Medical Examiner	
		15 <input type="checkbox"/> Other Medical	
		16 <input type="checkbox"/> Voice/Audio Analyst	
		17 <input type="checkbox"/> Hair/Fiber Expert	
		18 <input type="checkbox"/> Computer (Hardware/Software/Systems)	
		19 <input type="checkbox"/> Paralegal Services	
		20 <input type="checkbox"/> Legal Analyst/Consultant	
		21 <input type="checkbox"/> Jury Consultant	
		22 <input type="checkbox"/> Mitigation Specialist	
		23 <input type="checkbox"/> Duplication Services (See Instructions)	
		24 <input type="checkbox"/> Other (Specify) _____	

15. COURT ORDER	
Financial eligibility of the person represented having been established to the Court's satisfaction, the authorization requested in Item 12 is hereby granted.	
Signature of Presiding Judicial Officer or By Order of the Court _____	
Date of Order _____ Nunc Pro Tunc Date _____	
Repayment or partial repayment ordered from the person represented for this service at time of authorization.	
<input type="checkbox"/> YES <input type="checkbox"/> NO	

CLAIM FOR SERVICES AND EXPENSES		FOR COURT USE ONLY	
16. SERVICES AND EXPENSES (Attach itemization of services with dates)		AMOUNT CLAIMED	
a. Compensation			
b. Travel Expenses (lodging, parking, meals, mileage, etc.)			
c. Other Expenses			
GRAND TOTALS (CLAIMED AND ADJUSTED) :			

17. PAYEE'S NAME (First Name, M. I. Last Name including any Suffix), AND MAILING ADDRESS	
TIN: _____	
Telephone Number: _____	
CLAIMANT'S CERTIFICATION FOR PERIOD OF SERVICE FROM _____ TO _____	
CLAIM STATUS <input type="checkbox"/> Final Payment <input type="checkbox"/> Interim Payment Number _____ <input type="checkbox"/> Supplemental Payment	
I hereby certify that the above claim is for services rendered and is correct, and that I have not sought or received payment (compensation or anything of value) from any other source for these services.	
Signature of Claimant/Payee _____ Date _____	

18. CERTIFICATION OF ATTORNEY I hereby certify that the services were rendered for this case.	
Signature of Attorney _____ Date _____	

APPROVED FOR PAYMENT - COURT USE ONLY			
19. TOTAL COMPENSATTON		20 TRAVEL EXPENSES	
		21. Other Expenses	
		22 TOTAL AMOUNT APPROVED CERTIFIED	

23. <input type="checkbox"/> Either the cost (excluding expenses) of these services does not exceed \$300, or prior authorization was obtained.			
<input type="checkbox"/> Prior authorization was not obtained, but in the interest of justice of the Court finds that timely procurement of these necessary services could not await prior authorization, even though the cost (excluding expenses) exceeds \$300.			
Signature of Presiding Judicial Officer		Date	
		Judge/Mag. Judge Code	

24. TOTAL COMPENSATION		25. TRAVEL EXPENSES	
		26. OTHER EXPENSES	
		27. TOTAL AMOUNT APPROVED	

28. PAYMENT APPROVED IN EXCESS OF THE STATUTORY THRESHOLD UNDER 18 U.S.C. § 3006A(e)(3)			
Signature of Chief Judge, Court of Appeals (or Delegate)		Date	
		Judge Code	